



## CLAIMS AGAINST THE CITY OF TEMPE

For Damages to Persons or Personal Property

### NOTE

State Statute requires that claims *must* be filed with the City Clerk's Office within 180 days after the cause of action accrues.

By submitting the following information the claimant complies with the requirements of A.R.S. 12-821.01 regards claims against a municipality.

1. Name of Claimant \_\_\_\_\_ Spouse Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_
2. If Minor, name of Legal Guardian \_\_\_\_\_  
Guardian's Date of Birth \_\_\_\_\_
3. Address of Claimant \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_
4. Occurrence or event from which the claim arises:
  - a. Date of Loss \_\_\_\_\_ b. Time of Loss \_\_\_\_\_ c. Police Report No. \_\_\_\_\_
  - d. Location of Incident (*exact and specific*) \_\_\_\_\_  
\_\_\_\_\_
  - e. Specify the particular occurrence, event, act or omission you claim caused the injury or damage  
(*use additional paper if necessary*) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - f. State how or wherein the City of Tempe or its employees were at fault \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Give the name(s) of the City employees having knowledge of or involved in the incident (*if auto accident involving a City vehicle, please provide city vehicle description & license plate number, driver name and department*) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(turn over)

6. Describe claimants injury, property damage, auto damage (include year, make, and model of vehicle) or loss. If there were no injuries, state "no injuries"

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7. Dollar amount requested to settle this incident \$ \_\_\_\_\_ (Must provide amount)

a. Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, receipts etc.)

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8. Name and addresses of all witnesses, hospitals, doctors, etc. \_\_\_\_\_

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9. Any additional information that might be helpful in considering claim: \_\_\_\_\_

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**WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM!!**

(Sec A.R.S. 13-2310 Insurance Code 44-1220)

I have read the matters and statements made in the above claim I know the same to be true of my own knowledge, except as to those matters stated upon information or belief and as to such matters I believe the same to be true. I certify under penalty of perjury that the foregoing is true and correct.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Claimants Signature \_\_\_\_\_

**Federal Regulation – Bodily Injury Claims Only**

If you are presenting a bodily injury claim, you are required to provide the information requested in this section pursuant to Federal Law – Section 42, United States Code 1395y(b) (7) & (8). For additional information, go to [www.cms.hhs.gov/MandatoryInsRep](http://www.cms.hhs.gov/MandatoryInsRep).

Injured Party Name \_\_\_\_\_  
(show Name exactly as it appears on Social Security records)

Injured party Social Security Number \_\_\_\_\_

Injured Party Gender ☐ Male ☐ Female Injured Party Date of Birth \_\_\_\_\_

Medicare, Medicaid (AHCCCS) or SCHIP Health Ins Claim # \_\_\_\_\_

Is the injured party eligible (or will he/she be eligible within the next 36 months) for Medicare, Medicaid (AHCCCS) or the State Children's health Insurance Program (SCHIP)? ☐ Yes ☐ No